Appendix 12a
Prior Authorization Spell of Illness Attachment (PA/SOIA)
Completion Instructions
(Physical Therapy)

Do not use this attachment to request prior authorization to extend treatment beyond 35 treatment days for the same spell of illness. Use the Prior Authorization Therapy Attachment (PA/TA).

Timely determination of prior authorization is significantly increased by submitting thorough documentation when requesting prior authorization for a spell of illness. Carefully complete the Prior Authorization Spell of Illness Attachment (PA/SOIA) form, attach it to the Prior Authorization Request Form (PA/RF) and submit to the following address:

EDS
Attn: Prior Authorization, Suite 88
6406 Bridge Road
Madison, WI 53784-0088

Questions regarding the completion of the PA/RF and/or PA/SOIA may be directed to the fiscal agent's Policy/Billing Correspondence Unit. Telephone numbers are in Appendix 2 of Part A, the all-provider handbook.

Recipient Information:

Element 1 - Recipient's Last Name
Enter the recipient's last name from the recipient's current identification card.

Element 2 - Recipient's First Name
Enter the recipient's first name from the recipient's current identification card.

Element 3 - Recipient's Middle Initial
Enter the recipient's middle initial from the recipient's current identification card.

Element 4 - Recipient's Medicaid Identification Number
Enter the recipient's 10-digit identification number from the recipient's current identification card.

Element 5 - Recipient's Age
Enter the age of the recipient in numerical form (e.g., 21, 45, 60, etc.).

Provider Information:

Element 6 - Therapist's Name and Credentials
Enter the name and credentials of the primary therapist who is responsible for and participating in therapy services for the recipient. If the performing provider is a therapy assistant, enter his/her name and credentials, also enter the name of the supervising therapist.

Element 7 - Therapist's Medicaid Provider Number
Enter the eight-digit provider number of the therapist who is providing the authorized service (performing provider). If the performing provider is a therapy assistant, enter his/her provider number and the provider number of the supervising therapist. Rehabilitation agencies do not indicate a performing provider.

Element 8 - Therapist's Telephone Number
Enter the telephone number, including area code, of the therapist who is providing the authorized service (performing provider). If the performing provider is a therapy assistant, enter his/her telephone number and the telephone number of the supervising therapist.

Element 9 - Referring/Prescribing Physician's Name

Enter the name of the physician referring/prescribing evaluation/treatment.

Part A

Enter an "X" in the appropriate box to indicate a physical, occupational, or speech therapy spell of illness request.

Part B

Enter a description of the recipient's diagnosis and problems. Indicate what functional regression has occurred and what the potential is to reachieve the previous skill.

Part C

Attach a copy of the recipient's Therapy Plan of Care, including a current dated evaluation, to the Spell of Illness attachment before submitting the spell of illness request.

Part D

Enter the anticipated end date of the spell of illness in the space provided.

Part E

Attach the physician's dated signature on either the Therapy Plan of Care or copy of the physician's order sheet to this attachment.

Read the 'Prior Authorization Statement' before signing and dating the attachment.

Part F

The signature of the prescribing physician and the date must appear in the space provided. (A signed copy of the physician's order sheet is acceptable.)

Part G

The dated signature of the therapist providing evaluation/treatment must appear in the space provided.